MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

11379

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH
COUNTY: Anne Arundel County — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 829 Spa Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Anapolis
STREET ADDRESS (If rural, give location): 829 Spa Rd.

3. NAME OF DECEASED (Type or Print): (First) MAMIE (Middle) (Last) ALLEN

4. DATE OF DEATH: (Month) December (Day) 23, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: MAY 1900

9. AGE last birthday: 49 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: RICHARD ELEM

14. MOTHER'S MAIDEN NAME: MARIE CABELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: ROBERT FALTON

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Gunshot wound of aorta

981 166

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Gunshot wound of head

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ ~~CAUSE OF DEATH~~.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home
(CITY OR TOWN): Annapolis (COUNTY): A. A., (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): 12-23-49 8:35 a.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

SIGNATURE: H. J. McClafferty M. D. (Degree or title) — ADDRESS: 700 Fleet Street — DATE SIGNED: 12-23-49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) — DATE THEREOF: 12-26-49 — NAME OF CEMETERY OR CREMATORY: Carpenters Hill — LOCATION (City, town, or county): Jones Station (State): Md.

DATE REC'D BY LOCAL REG.: Dec. 26, 1949 — REGISTRAR'S SIGNATURE: W. O. Smith

24. FUNERAL DIRECTOR: J. B. Johnson — ADDRESS: Annapolis Md.

RECEIVED
DEC 30 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11380

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Pasadena
LENGTH OF STAY (in this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS Ritchie Highway

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Pasadena
STREET ADDRESS (If rural give location) Ritchie Highway

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
MARY	Marie	BARNES	DEC	31	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	W	widowed	1-26-1882	67 yrs.	11	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Elsie Richardson Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cardiac Decompensation	3 weeks
420.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic Heart Disease	
93d	(c) Arteriosclerosis general.	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
No.				

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 12/5, 1949, to 12/31, 1949, that I last saw the deceased alive on 12/30, 1949, and that death occurred at 7:30A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Bobby L. Jones	M.D.	7 Central Ave S.W. Glen Burnie Md.	12/31/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-3-50	Glen Haven Cemetery	Glen Burnie, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 3, 1949	[signature]	B. S. Hopping & Son	Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

RECEIVED
JAN 4 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11381

CERTIFICATE OF DEATH

Reg. Dist. No. 191 25

1. PLACE OF DEATH: COUNTY Anarundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dorsey. LENGTH OF STAY (in this place) 4 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE maryland COUNTY anarundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dorsey md.
STREET ADDRESS (If rural give location) Dorsey md.

3. NAME OF DECEASED (Type or Print) (First) Darlene (Middle) Hope (Last) Boone
4. DATE OF DEATH (Month) 12 (Day) 17 (Year) 1949
5. SEX Female
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE
8. DATE OF BIRTH 5 august 49
9. AGE last birthday 0 mo. If under 1 year Months 4 Days 12 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) maryland
12. CITIZEN OF WHAT COUNTRY? Anarundel
13. FATHER'S NAME David Carrol Boone
14. MOTHER'S MAIDEN NAME Emma Mae Boone
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT —

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Suffocation, respiratory distress

501 Antecedent cause(s)

106c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Tracheo-bronchitis — 2 days.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 15 Dec., 1949, to 17 Dec., 1949, that I last saw the deceased alive on 15 Dec., 1949, and that death occurred at 7:15 A.m., from the causes and on the date stated above.

SIGNATURE George C Grolean (Degree or title) ADDRESS Clbridge md DATE SIGNED 17 Dec 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Dec. 18, 1949
NAME OF CEMETERY OR CREMATORY Taylors Family
LOCATION (City, town, or county) (State) Grays, Md.
DATE REC'D BY LOCAL REG. Dec 17, 1949
REGISTRAR'S SIGNATURE John B. Lingham Per.
24. FUNERAL DIRECTOR Easton Sons Ellicott City Md. ADDRESS

Received Dec 24, 1949 Ida M. Whiteis B. E. L. Registrar District 25.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN. 2 1950
BUREAU V. A.

D. Lenhart

11382

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. Co. General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 16 N. Linden

3. NAME OF DECEASED (Type or Print) (First) De Witt (Middle) (Last) Brown
4. DATE OF DEATH (Month) 12 (Day) 18 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. ~~SINGLE,~~ MARRIED, ~~WIDOWED, DIVORCED,~~ (Specify)
8. DATE OF BIRTH 5-28-1891
9. AGE last birthday 58 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Insurance
11. BIRTHPLACE (State or foreign country) A. A. Co Md
12. CITIZEN OF WHAT COUNTRY? N. S. A.

13. FATHER'S NAME Benjiman F. Brown
14. MOTHER'S MAIDEN NAME Susan Collenson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) I
16. SOCIAL SECURITY NO.
17. INFORMANT Annie V. Brown Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardio Vascular dens	5 yrs
93d	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1945, to 12.18, 1949, that I last saw the deceased alive on 12.18.49, 19—, and that death occurred at 8:30 P m., from the causes and on the date stated above.

SIGNATURE E. Lenhart (Degree or title) MD ADDRESS Easyport Md DATE SIGNED 12/18/49

23. ~~BURIAL, CREMATION REMOVAL,~~ (Specify)
DATE THEREOF 12-21-1949
NAME OF CEMETERY OR CREMATORY Cedar Bluff
LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. 12/21/49
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 24 1949
BUREAU V. S.

RECEIVED
DEC 24 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11383

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Balt.City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 1 yr. 4 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 824 Hanover Street

3. NAME OF DECEASED (Type or Print) (First) Fitzhugh (Middle) (Last) Carter			4. DATE OF DEATH (Month) 12/6/49 (Day) (Year) 19	
5. SEX: male	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: ~~not known~~ about 1882	9. AGE last birthday: 67 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: Dick Carter		14. MOTHER'S MAIDEN NAME: not known		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): ******	16. SOCIAL SECURITY No.: ******	17. INFORMANT AND ADDRESS: Hospital Records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) General Paresis	known since 7/6/48
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Senile Psychosis	known since 7/6/48

025

30b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ******	19b. MAJOR FINDINGS OF OPERATION: ******	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify): ******	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ******	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour): ******	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? *****

22. I hereby certify that I attended the deceased from 7/6/48, 19....., to 12/6/49, 19....., that I last saw the deceased alive on 12/6/49, 19....., and that death occurred at 6:50 P.M. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Thorgerstein	M.D.	Crownsville, Md.	12/7/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Dec. 10-49	NAME OF CEMETERY OR CREMATORY: Mt Calvary	LOCATION (City, town, or county) (State): A. A. Co Md
DATE REC'D BY LOCAL REG.: Dec. 8/49	REGISTRAR'S SIGNATURE: A.W. Hedrick	24. FUNERAL DIRECTOR: James A Hayes	ADDRESS: 638 N. Gilmor St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11384

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: ANNE ARUNDEL

City or town: CLEARWATER BEACH
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 YRS.

Hospital, institution, or street address where death occurred: 904 WATERVIEW DRIVE

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ANNE ARUNDEL

City or town: CLEARWATER BEACH
(If outside city or town limits, write RURAL and give nearest town)

Street No. 904 WATERVIEW DRIVE
(If rural, give LOCATION)

2.(a) If veteran, name war: NONE

3.(a) FULL NAME: HARRY VICTOR COLE

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	White	widowed

6.(b) Name of husband or wife: ELIZABETH COLE

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): NOV. 10, 1867

8. AGE: Years	Months	Days	If less than one day
82	1	10	..... hrs. ..... min.

9. Birthplace: BALTIMORE, Md.
(Town, county, and state)

10. Usual occupation: MACHINE OPERATOR

11. Industry or business: CHEMICAL PLANT

FATHER
12. Name: UnKnown
13. Birthplace:

MOTHER
14. Maiden name: UnKnown
15. Birthplace:

16. Informant: MR. MELVIN R. COLE

Address: 108 S. PAYSON ST.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: 12-22-49 (month) (day) (year)

Cemetery or crematory: Loudon PARK

Location: BALTIMORE, Md.

19. Funeral director: GEORGE L. SCHWAB

Address: 2101 FREDERICK AVE., BALTO., Md.

19. 12/21 19 49 (Date rec'd by registrar) H.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20 1949 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 11 1949 to Dec. 20 1949 and that I last saw him alive on December 15 1949

Immediate cause of death: Heart failure

	DURATION
Due to: Arteriosclerotic Cardio Vascular Disease	5 years
Due to:	
Other conditions: 422.1 93d (Include pregnancy within 3 months of death)	

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Brady Smith, M.D. M. D. or other

Address: RIVIERA BEACH, MD. Date signed 12/20/49

11385

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mulberry Hill
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mulberry Hill (Annapolis)
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Willie (Middle) Cook (Last)

4. DATE OF DEATH (Month) Dec. (Day) 21 (Year) 1949

5. SEX Male
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Dec. 20, 1913
9. AGE last birthday 36 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) A.A. Co. Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joseph Cook
14. MOTHER'S MAIDEN NAME Elenora Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mary Hunt

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Epilepsy

353.3 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

85 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-11, 1949, to 12-21, 1949, that I last saw the deceased alive on 12-20-, 1949, and that death occurred at 11 30 A m., from the causes and on the date stated above.

SIGNATURE A. Allen (Degree or title) MD ADDRESS 11 Carroll DATE SIGNED 12-22-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Dec. 23, 1949
NAME OF CEMETERY OR CREMATORY Broadneck
LOCATION (City, town, or county) Skidmore (State) Md.

DATE REC'D BY LOCAL REG. Dec. 23, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR J.B. Johnson ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 24 1949
BUREAU V. S.

Evidence for change of birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11386

FILM No. G 123 DEC 22 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (in this place) 9 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 19 Hill St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY AA.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyne
STREET ADDRESS (If rural give location) 905 Potasco Ave.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Ellen (Last) Culbertson

4. DATE OF DEATH: (Month) 12 (Day) 10 (Year) 1949

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M | 8. DATE OF BIRTH: Nov. 22, 1882 | 9. AGE last birthday: 67 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Annapolis Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Reese | 14. MOTHER'S MAIDEN NAME: Sara Frances Laramore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Mrs. Elsie Ellen Grant

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Vascular Accident	7 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Vascular Accident	19 days
	(c) Hypertension Arteriosclerosis	?

331
83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/2/49 to 12/10/1949, that I last saw the deceased alive on 12/10/, 1949, and that death occurred at 8:00 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank M. Shipley	M.D.	63 College Ave. Annapolis	12/10/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
B.	12-14-49	Dale (Md.)	Dale.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Dec 11, 1949	Ida M. Whitson	James L. McCarthy	130 E. Fort Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11387

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY A.A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn
LENGTH OF STAY (in this place): 5 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Off Ordinance Depot Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn
STREET ADDRESS (If rural, give location): Off Ordinance Depot Road

3. NAME OF DECEASED (Type or Print): (First) LAURA (Middle) BELLE (Last) DECK

4. DATE OF DEATH: (Month) 12 (Day) 9 (Year) 19 49

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: 5/27/1867

9. AGE last birthday: 82 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Padgett

14. MOTHER'S MAIDEN NAME: Olive Rodrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Family - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac - Decompensation - 5/23/49

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Arterio - Sclerotic Cardio Vascular Disease
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

450.1
932

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 23, 1949, to Dec 9, 1949, that I last saw the deceased alive on Dec - 9, 1949, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Paul Lubin M.D. ADDRESS 320 Patapsco Ave - Balto, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) B

DATE 12/12/49

NAME OF CEMETERY OR CREMATORY Harpers

LOCATION (City, town, or county) (State) Harpers Ferry, W. Va.

DATE REC'D BY LOCAL REG. Dec 14 1949

REGISTRAR'S SIGNATURE Ida M. Whitson

24. FUNERAL DIRECTOR James L. McCleery ADDRESS 130 E. Fort Av

Dr. Kubin

RECEIVED
DEC 14 1949
BUREAU V. S.

Evidence for addition of #18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

11388

CERTIFICATE OF DEATH

FILM No. G 12 JAN 31 1950 FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Severna Park, Md. Box 277, Severna Park

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park
STREET ADDRESS (If rural, give location) Box 277

3. NAME OF DECEASED (Type or Print): (First) James (Middle) P. (Last) Dent, Jr.

4. DATE OF DEATH: (Month) Dec. (Day) 13, (Year) 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 4-12-48

9. AGE last birthday: 1 yrs. If under 1 year: Months 0 Days 1 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Va

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James F. Dent

14. MOTHER'S MAIDEN NAME: Ruth Louise Deering

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: James F. Dent Severna Park Box 277

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Gastro-enteritis, acute (1-30-50- ams)

571.0

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

119a

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☐, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE: Russell S Fisher (Degree or title) MD ADDRESS 700 Fleet St. Balto. 2, Md. DATE SIGNED Dec. 14, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 12-16-49

NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial

LOCATION (City, town, or county) (State): Glen Burnie, Maryland

DATE REC'D BY LOCAL REG.: Dec. 16, 1949

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: B.L. Hopping and Son ADDRESS: Annapolis Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

RECEIVED
DEC 17 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11389

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 1 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY St. Mary
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oakley
STREET ADDRESS (If rural, give location) none

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) (Last) Dent
4. DATE OF DEATH: (Month) (Day) (Year) 12/16/49 19

5. SEX: female
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: not known
9. AGE last birthday: 83(?) yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: not known
14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No. ********
17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Degeneration — known since 11/16/49

422,2 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Senile Psychosis — known since 11/16/49

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: none
(CITY OR TOWN): none (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/16/49, 19..., to 12/16/49, 19..., that I last saw the deceased alive on 12/16/49, 19..., and that death occurred at 1:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Jacob Manguelsen M.D. Crownsville, Md. 12/16/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 12/21/49
NAME OF CEMETERY OR CREMATORY: Crownsville
LOCATION (City, town, or county) (State): Crownsville Md

DATE REC'D BY LOCAL REG.: 12-21-49
REGISTRAR'S SIGNATURE: E. Joyce Locke Asst
24. FUNERAL DIRECTOR: Supt Hospital
ADDRESS: Crownsville Md

RECEIVED
DEC 23 1949
BUREAU V. S.

Evidence for addition of #18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

11390

CERTIFICATE OF DEATH

FILM No. G 12 JAN 31 1950 FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH · COUNTY Anne Arundel · MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland · COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park
STREET ADDRESS (If rural, give location) Box 277

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
RUTH	MARGARET	DENT	December 14, 1949 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
female	white	single	May 28, 1947	2 yrs.	6	16		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Va	

13. FATHER'S NAME: James F. Dent

14. MOTHER'S MAIDEN NAME: Ruth Louise Deering

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: James F. Dent Severna Park Box 277

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Gastro-enteritis, acute.	
571.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) (1-30-50 - ams)	
120a	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Russell S Fisher	MD	700 Fleet Street, Baltimore 2, Md.	12-14-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	12-16-49	Glen Have Memorial	Glen Burnie, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Dec. 16, 1949	[signature]	B.L. Hopping and Son	Annapolis,

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
DEC 17 1949
BUREAU V. S.

11391

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dorsey
LENGTH OF STAY (in this place) 20 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Race Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dorsey
STREET ADDRESS (If rural give location) Race Road

3. NAME OF DECEASED (Type or Print) (First) MILDRED (Middle) LUCILLE (Last) DORSEY

4. DATE OF DEATH (Month) December (Day) 11, (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Aug. 22, 1905
9. AGE last birthday 44 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Housework
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Dallas F. Heilman
14. MOTHER'S MAIDEN NAME Carrie J. McAdoo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 579-09-3429
17. INFORMANT George T. Heilman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	Few min.
420.1 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chr. Myocarditis	1 yr.
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Common Cold — 1 wk.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☑
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/9/49, to 12/11/49, that I last saw the deceased alive on 12/10/49, and that death occurred at 7 a.m., from the causes and on the date stated above.

SIGNATURE Frank Shipley (Degree or title), ADDRESS Savage, Md. DATE SIGNED 12/13/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 12/14/49
NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park
LOCATION (City, town, or county) (State) Dorsey, Maryland

DATE REC'D BY LOCAL REG. 12-14-49
REGISTRAR'S SIGNATURE Clara Caslup
24. FUNERAL DIRECTOR Easton Sons, ADDRESS Ellicott City, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 29 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11392

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. Co General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md
STREET ADDRESS (If rural give location) 213 King Geo St

3. NAME OF DECEASED (Type or Print): (First) Helen (Middle) Du (Last) Barry

4. DATE OF DEATH: (Month) 12 (Day) 17 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 4-10-1869

9. AGE last birthday: 80 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country): New York State

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Beekman Du Barry

14. MOTHER'S MAIDEN NAME: Helen B. Bratt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Comde. G.B. Sutherland Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause (a)	Acute Cardiac Failure	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Chronic Myocarditis	5 years
(c)	Rheumatic Fever	unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. General arterio-sclerosis & hypertension — unknown

415
93d

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 2, 1949, to Dec. 16, 1949, that I last saw the deceased alive on Dec. 16, 1949, and that death occurred at 5:20 A. m., from the causes and on the date stated above.

SIGNATURE John M. Cayley (Degree or title) M.D. ADDRESS Annapolis Maryland DATE SIGNED 12/20/49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 12-19-49 | NAME OF CEMETERY OR CREMATORY West Point N.Y. | LOCATION (City, town, or county) West Point (State) N.Y.

DATE REC'D BY LOCAL REG. Dec. 19, 1949 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR John M. Cayley Son ADDRESS Annapolis Md.

VS. A15

RECEIVED
DEC 22 1949
BUREAU V. S.

11393

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis,
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 25 Wagner Street

3. NAME OF DECEASED (Type or Print) (First) HARRY (Middle) L (Last) ELLINGHAUSEN

4. DATE OF DEATH (Month) (Day) (Year) 12-16-49 19

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH 11-5-1872
9. AGE last birthday 77 yrs. If under 1 year Months 1 Days 11 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Merch.
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Hemman Ellinghausen
14. MOTHER'S MAIDEN NAME Elizabeth Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT Mr. Charles Ellinghausen Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	?
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Possible Carcinoma of Lung, L.	?
	(c)	

002
13b

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/20, 1949, to 12/16, 1949, that I last saw the deceased alive on 12/16/, 1949, and that death occurred at 9 10p m., from the causes and on the date stated above.

SIGNATURE Maurice W. Lawrence (Degree or title) ADDRESS Annapolis, Md DATE SIGNED 12/19/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 12-20-49
NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery
LOCATION (City, town, or county) (State) Annapolis, Maryland

DATE REC'D BY LOCAL REG. Dec. 20, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Ben L. Hopping and Son ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 22 1949
BUREAU V. S.

AGE & SURNAME: BAPT. CER. FILMED G124 2-15-50 L

MARYLAND STATE DEPARTMENT OF HEALTH

11394

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater
LENGTH OF STAY (In this place) 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Woodland Beach

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater
STREET ADDRESS (If rural give location) Woodland Beach

3. NAME OF DECEASED (Type or Print): (First) DANIEL (Middle) A. (Last) FLANNIGAN, Sr. ~~FLANAGAN~~

4. DATE OF DEATH: (Month) Dec. (Day) 31 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, WIDOWED, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: Apr. 8 1878 1879

9. AGE: Last birthday 71 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give k'nd of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Transit Company.

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Matthew Flannigan

14. MOTHER'S MAIDEN NAME: Elizabeth Lynch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY No.:

17. INFORMANT: Daniel A. Flannigan Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the under ying cause last	(b) Coronary sclerosis.	unknown
	(c)	

420.1 / 94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John M. Caffy, M.D., Deputy Medical Examiner Annapolis, Md. 12/31/49

23. BURIAL, CREMATION OR REMOVAL (Specify) Burial — DATE THEREOF Jan. 4, 1949 — NAME OF CEMETERY OR CREMATORY Mt. Olivet — LOCATION (City, town, or county) Washington D.C. (State)

DATE REC'D BY LOCAL REG. Dec. 31, 1949 — REGISTRAR'S SIGNATURE Edward Callenson

24. FUNERAL DIRECTOR Wasther Funeral Home — ADDRESS 301 E. Capitol St. Washington D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JAN 9 1950
BUREAU F. S.

11395

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Anne Arundel

City or town: ~~Baltimore 25~~ (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life Brooklyn

Hospital, institution, or street address where death occurred: 109 W 5th Ave

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Brooklyn Park (If outside city or town limits, write RURAL and give nearest town)

Street No.: 109 W 5th Ave (If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Louisa Friedhofer

3. (b) Social Security Number: —

4. Sex: fem

5. Color or race: wh-

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Charles V. Friedhofer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 6.5.1872

8. AGE: Years: 77 Months: 6 Days: 14 If less than one day ..... hrs. ..... min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: —

FATHER

12. Name: Joseph Fay

13. Birthplace: a

MOTHER

14. Maiden name: Caroline D Michaelis

15. Birthplace: Germany

16. Informant: son. Albert F Friedhofer

Address: 109 W 5th Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/23/49 (month) (day) (year)

Cemetery or crematory: London Park Cem.

Location: Frederick Ave (Md)

18. Funeral director: James H. Lyons

Address: 4001 Ritchie Hgy

19. 12/22 19 49 (Date recd by registrar) Abr. Hiduck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12.19. 1949 at 3:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 1942 to Dec. 19 49 and that I last saw her alive on 12.19. 1949

	DURATION
Immediate cause of death: Coronary thrombosis	15 min
Due to: Coronary sclerosis	?
Due to:	
Other conditions: Hypertension.	?

420.1
94a

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: P. J. Grimaldi Injured at work?

23. SIGNATURE: Mr Henry G Summers M. D. or other

Address: 1045 Pasadena Date signed: 12.19.49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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11396

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel County MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mayo; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY Mayo, Anne Arundel County, Md.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Priscilla (Last) Gardner

4. DATE OF DEATH: (Month) Dec. (Day) 14 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 13, 1882

9. AGE last birthday: 67 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Shadyside, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Edward Bull

14. MOTHER'S MAIDEN NAME: Rosella Popham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-14-3400

17. INFORMANT: Son

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocarditis, chronic	5 years
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) Arteriosclerosis	5 "
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 6, 1949, to Dec. 14, 1949, that I last saw the deceased alive on Dec. 14, 1949, and that death occurred at 5.10 p.m., from the causes and on the date stated above.

SIGNATURE: Vincent Gorsuch (Degree or title) M.D. ADDRESS: Mayo, Anne Arundel County, Maryland DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Dec. 17-49 | NAME OF CEMETERY OR CREMATORY: Mayo Memorial Park | LOCATION (City, town, or county): Mayo (State) Md

DATE REC'D BY LOCAL REG.: 12/15/49 | REGISTRAR'S SIGNATURE: Edward Collinson | 24. FUNERAL DIRECTOR: D. A. Handley & Son ADDRESS: Galesville Md

VS. A15

RECEIVED
DEC 20 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11397

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 165 Green St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Annapolis
STREET ADDRESS (If rural give location) Ferry Farms

3. NAME OF DECEASED (Type or Print) (First) Agnes (Middle) G. (Last) Geraci

4. DATE OF DEATH (Month) 12 (Day) 7 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED,~~ (Specify)
8. DATE OF BIRTH June 1st 1882
9. AGE last birthday 67 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Annapolis Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Edward Smith
14. MOTHER'S MAIDEN NAME Katherine Purdy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Frank B. Geraci Annapolis Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) uremia	4 days
442 48b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerotic cardiovascular renal disease	5 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of fundus uteri —

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1946, to Dec 7, 1949, that I last saw the deceased alive on 12/7, 1949, and that death occurred at 8:20 P m., from the causes and on the date stated above.

SIGNATURE S. Bossuch M.D. (Degree or title) ADDRESS Annapolis Md DATE SIGNED 12/10/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 12-10-49
NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery
LOCATION (City, town, or county) (State) Annapolis Md.

DATE REC'D BY LOCAL REG. 12/9/49
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 15 1949
BUREAU V. S.

Evidence for change of birth date is on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11398

CERTIFICATE OF DEATH

FILM No. G 123 DEC 20 1949

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md. | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Gloucester Apt. G.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md
STREET ADDRESS (If rural, give location) Gloucester Apt.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Angelo	J.	Zesaci		12	11	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	M	Oct 9 1874	75 yrs.	2	2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Barber Ret.	Barber	Annapolis Md	U.S.A.

13. FATHER'S NAME Onofrio Zesaci
14. MOTHER'S MAIDEN NAME Mary E. Noonan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Mrs Angelo Zesaci Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uraemia	2 days.
592 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 131a	(b) Arteriosclerosis	several yrs
	(c) Cr. Interstitial Nephritis	several yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	—	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
no				

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
—			m.		—

22. I hereby certify that I attended the deceased from Dec 25, 1948, to Dec 11, 1949, that I last saw the deceased alive on Dec 11, 1949, and that death occurred at 9.50 P m., from the causes and on the date stated above.

SIGNATURE J. Oliver Parris (Degree or title) ADDRESS Annapolis, Md. DATE SIGNED 11/12/49

23. BURIAL, CREMATION, ~~REMOVAL~~ (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	12-14-49	St Mary's	Annapolis Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
12/13/49	[illegible] Smith	John W. Taylor Son	Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11399

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel. STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie | LENGTH OF STAY (in this place) 13 years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 805 Crain Highway, S.E.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
STREET ADDRESS (If rural give location) 805 Crain Highway, S.E.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
IDA	MYRTLE	GIBBONS	December	19	1949.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	W		April 20 1884	65 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		North Keyes Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Dalton E. Gibbons	Margaret Emma Marcoe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	Irving Gibbons, husband

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Arteriosclerotic Heart Disease	several years.
420.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) Arteriosclerosis, General.	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None.		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
None.				

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from October 1, 19 49., to December 19 19 49., that I last saw the deceased alive on December 17, 19 49., and that death occurred at 8:30 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Bobby L. Jones	M.D.	7 Central Avenue S.W. - Glen Burnie	12/19/49.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	DEC. 22, 1949.	LOUDON PARK	BALTIMORE, MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
12/20/49	L. J. DeAlba	Thomas W. Singleton	Glen Burnie, Md.

VS. A15

RECEIVED
DEC 23 1949
BUREAU V. S.

Evidence for change of birth date is on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11400

CERTIFICATE OF DEATH

Reg. Dist. No. 21

FILM No. G 123 DEC 29 1949

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Best Gate | LENGTH OF STAY (In this place): 12 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Best Gate

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Best Gate
STREET ADDRESS (If rural give location): Best Gate

3. NAME OF DECEASED (Type or Print): (First) Barbara (Middle) Ann (Last) Glenn

4. DATE OF DEATH: (Month) 12 (Day) 16 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 12 /16 /1947

9. AGE last birthday: 25 yrs. | If under 1 year: Months 2 Days 5 | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Newburg New York

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: William B. Glenn

14. MOTHER'S MAIDEN NAME: Alice Gross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Alice Glenn

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

157 Immediate cause (a) Carcinoma of head of pancreas

469 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) Annapolis | (COUNTY) Anne Arundel | (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-16, 1949, to 12-16, 1949, that I last saw the deceased alive on 12-15, 1949, and that death occurred at 2:15 P m., from the causes and on the date stated above.

SIGNATURE W. T. Allen | (Degree or title) M.D. | ADDRESS 10 Carroll St | DATE SIGNED 12-19-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 12/20/1949 | NAME OF CEMETERY OR CREMATORY Fowlers Cemetery | LOCATION (City, town, or county) Best Gate, (State) Maryland

DATE REC'D BY LOCAL REG. Dec. 20, 1949 | REGISTRAR'S SIGNATURE [illegible] O'Connell

24. FUNERAL DIRECTOR: Mrs. Charles E. Hicks & Son | ADDRESS 45 Northwest St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11401

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Ann Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Odenton
LENGTH OF STAY (in this place): 3 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: New Telegraph Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Towson
STREET ADDRESS (If rural, give location): 1624 Yakona Rd. ✓

3. NAME OF DECEASED (Type or Print): (First) Marcella (Middle) Virginia (Last) Granger

4. DATE OF DEATH: (Month) Dec. (Day) 1 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: Mar. 21, 1876

9. AGE last birthday: 73 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Redmond

14. MOTHER'S MAIDEN NAME: Mary Dunne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT AND ADDRESS: Mrs. Grace Fairale - Odenton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 **Immediate cause** (a) Cardio-Vascular Disease — Interval Between Onset and Death: 5 yr.

526 **Antecedent cause(s)**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c) Cystitis & Cystitis — 10 yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Possibly Cancer of bladder — 2-3 yr.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 10, 1949, to Dec 1, 1949, that I last saw the deceased alive on Dec. 1, 1949, and that death occurred at 11:45 A m., from the causes and on the date stated above.

SIGNATURE: Chas. L. Ball Jr — (Degree or title): MD — ADDRESS: Linthicum — DATE SIGNED: (Dec 1, 49) mcf

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 12/3/49 — NAME OF CEMETERY OR CREMATORY: Lorraine Cem. — LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE REC'D BY LOCAL REG.: 12/2/49 — REGISTRAR'S SIGNATURE: A. W. Hedrick

24. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

11402

Reg. Dist. No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Patapsco Park; LENGTH OF STAY (In this place) 4 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS 207 Berlin Av. Balto. 25

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A.A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Patapsco Park (Baltimore 25); STREET ADDRESS (If rural, give location) 207 Berlin Av.

3. NAME OF DECEASED (Type or Print): ~~(First)~~ THOMAS ~~(Middle)~~ MIDDLE S. ~~FIRST.~~ KIRKLAND (Last) GRIFFIN

4. DATE OF DEATH: (Month) Dec. (Day) 1 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): —

8. DATE OF BIRTH: Nov. 26, 1949

9. AGE last birthday: yrs.; If under 1 year: Months, Days 3, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Roland Griffin

14. MOTHER'S MAIDEN NAME: Regena Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY No.:

17. INFORMANT: Roland Griffin

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Prematurity (7½ months) — Interval between onset and death:

776 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 159 (b) (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Thos M. Claffy M.D. Deputy Medical Examiner, Annapolis Md 12/1/49.

23. BURIAL, CREMATION REMOVAL (Specify) Burial; DATE THEREOF 12/5/49; NAME OF CEMETERY OR CREMATORY Mt Calvary; LOCATION (City, town, or county) (State) a a co., md

DATE REC'D BY LOCAL REG. 12/2/49; REGISTRAR'S SIGNATURE A. W. Hedrick

24. FUNERAL DIRECTOR ADDRESS D. L. Brown & Son 108 W. Montgomery St

VS. A15A

Evidence for addition of 23b shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

FILM No. G 123 DEC 28 1949

11403

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL — STATE MARYLAND — LENGTH OF STAY (in this place)
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ft Geo. G. Meade
HOSPITAL OR INSTITUTION OR STREET ADDRESS STATION HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: COUNTY ANNE ARUNDEL — STATE MD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ODENTON
STREET ADDRESS (If rural give location) BOX 326

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) HOWARD (Last) HOFFMAN

4. DATE OF DEATH: (Month) DEC (Day) 12 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: MAY 22, 1874

9. AGE last birthday: 75 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SOLDIER-RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: US ARMY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: DANIEL HOFFMAN

14. MOTHER'S MAIDEN NAME: ELIZABETH —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) Spanish-Amer CUBAN

16. SOCIAL SECURITY NO. —

17. INFORMANT: MRS CHARLES H. HOFFMAN

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260 61

Immediate cause (a) Coronary Thrombosis — Interval between onset and death: 60 Min.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic C.V. disease — indefinite

(c) Diabetes Mellitus — or

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 25 Nov. 1949

19b. MAJOR FINDINGS OF OPERATION: Arteriosclerotic Obstruction, left leg

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 17 Nov., 1949, to 12 Dec., 1949 that I last saw the deceased alive on 12 Dec., 1949, and that death occurred at 11 30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

F. Robert Haase, M.D. 5515 Hilltop Av. Balto 6, Md 12/13/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Dec. 15, 1949 — NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery — LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REG.: 13 Dec 49 — REGISTRAR'S SIGNATURE: James E Hayes Registrar — 24. FUNERAL DIRECTOR: John O. Mitchell & Son. — ADDRESS: 1900 Eutaw Pl.

DEC 16 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11404

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: WATERBURY
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: CROWNSVILLE POST OFFICE

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: WATER BURY
STREET ADDRESS (If rural give location): CROWNSVILLE P.O.

3. NAME OF DECEASED (Type or Print): (First) JOSEPH (Middle) (Last) HOPPA

4. DATE OF DEATH: (Month) 12 (Day) 4 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: Sept 9, 1873

9. AGE last birthday: 76 yrs. If under 1 year: Months 2 Days 25 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER. (RETIRED)

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (State or foreign country): POLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: JOSEPH HOPPA JR.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Pneumonia Hypostatic — Interval Between Onset and Death: 3 days

447 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
87c (b) Hypertension / Arterio Sclerosis — 3 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Enlarged Prostate

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 30, 19 49, to Dec 4, 19 49, that I last saw the deceased alive on Dec 3, 19 49, and that death occurred at 1.15P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Othmar Newar M.D. Millersville Maryland

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL

DATE THEREOF: 12-7-49

NAME OF CEMETERY OR CREMATORY: OUR LADY OF THE FIELDS

LOCATION (City, town, or county) (State): MILLERSVILLE MD.

DATE REC'D BY LOCAL REG.: 12-4-49

REGISTRAR'S SIGNATURE: E.T. Joyce Local Reg

24. FUNERAL DIRECTOR: B.L. HOPPING & SON

ADDRESS: ANNAPOLIS, Md.

RECEIVED
DEC 7 1949
BUREAU V. S

11405

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hosptial

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport,
STREET ADDRESS (If rural give location) 703 Severn Ave.

3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) B. (Last) Hughes
4. DATE OF DEATH (Month) 12- (Day) 5- (Year) 1949
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH April 23, 1874
9. AGE last birthday 75 yrs. If under 1 year Months 7 Days 12 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retied Gavernment
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Annapolis, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Hughes
14. MOTHER'S MAIDEN NAME Mary Brady
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Mary B. Hughes

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	Sudden
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) Arterio Sclerosis	Several years
	(c) Myocarditis (chr)	unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chr Bronchitis — Several years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-28, 1949, to 12-5, 1949, that I last saw the deceased alive on 12-5, 1949, and that death occurred at 8 30 a.m., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M. D ADDRESS Annapolis Md DATE SIGNED 12.6.49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 12-7-49
NAME OF CEMETERY OR CREMATORY St. Mary's Cemtery
LOCATION (City, town, or county) (State) Annapolis, Maryland
DATE REC'D BY LOCAL REG. Dec. 7, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR B.L. Hopping and Son ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 9 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11406

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS ~~George~~

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) George (Middle) H. (Last) Hutton

4. DATE OF DEATH (Month) Dec (Day) 9 (Year) 1949

5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed
8. DATE OF BIRTH 12-20-72
9. AGE last birthday 76 yrs. If under Months. I year Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oysterman
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Churchton, Md.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Jacob Hutton
14. MOTHER'S MAIDEN NAME Maria Holland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. no
17. INFORMANT AND ADDRESS Clarence Hutt Churchton Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
444	Immediate cause	(a) Acute Myocarditis	15 days
	Antecedent cause(s)		
93a	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterial Hypertension	1 year
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 25, 1949, to Dec 9, 1949, that I last saw the deceased alive on Dec 9, 1949, and that death occurred at 12 30 A. m., from the causes and on the date stated above.

SIGNATURE R. L. Richardson (Degree or title) M.D. ADDRESS 110 - Clay St. Annapolis Md. DATE SIGNED Dec 9, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Dec 11, 1949
NAME OF CEMETERY OR CREMATORY Franklin Cem.
LOCATION (City, town, or county) Churchton (State) Md

DATE REC'D BY LOCAL REG. Dec 10, 1949
REGISTRAR'S SIGNATURE D. B. Dent.
24. FUNERAL DIRECTOR T. A. Hardesty + Son ADDRESS Galesville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. AN

RECEIVED
DEC 13 1949
BUREAU V. S.

11407

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balti.City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (in this place) 5 yr. 9 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore,
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital	STREET ADDRESS (If rural, give location) no home

3. NAME OF DECEASED (Type or Print) (First) Sarah (Middle) (Last) Irving			4. DATE OF DEATH (Month) 12/23/49 (Day) (Year) 19	
5. SEX female	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH about 1883 ~~not known~~	9. AGE last birthday 66(?) yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) not known	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) not known	12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME not known		14. MOTHER'S MAIDEN NAME not known		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT Hospital Records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	known
Antecedent cause(s)		for 7 days
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Senile Psychosis	known since 3/27/44

331
830

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) none	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	(CITY OR TOWN) none (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) none m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 3/27/44, 19....., to 12/23/49, 19....., that I last saw the deceased alive on 12/23/49, 19....., and that death occurred at 5:10 A.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Marquette	M.D.	Crownsville, Md.	12/23/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Dec. 26, 1949	NAME OF CEMETERY OR CREMATORY Crownsville	LOCATION (City, town, or county) (State) Crownsville, Md.
DATE REC'D BY LOCAL REG. 12/27.49	REGISTRAR'S SIGNATURE E. F. Joyce Local Reg.	24. FUNERAL DIRECTOR Supt. Hospital	ADDRESS Crownsville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 25 1949
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11408

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH COUNTY: A.A. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Md. COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn Park — LENGTH OF STAY (in this place): 3 Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn Park
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural, give location): # 4 West Third Avenue

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): HAROLD JAMIESON			4. DATE OF DEATH (Month) (Day) (Year): 12/29/49 19		
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M	8. DATE OF BIRTH: 3/7/1896	9. AGE last birthday: 53 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman	10b. KIND OF BUSINESS OR INDUSTRY: G E Co.	11. BIRTHPLACE (State or foreign country): Troy, New York ~~[illegible]~~	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME: Unknown		14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS: Family - Same			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) coronary occlusion

420.1 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) hypertensive carded vasc disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1948, to Dec 29 1949, that I last saw the deceased alive on Dec 29 1949, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Philip W Kirsten		302 Pedagogo Av	12/30/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
B	1/2/50	Schenectady	Schenectady, New York

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Dec 30, 1949	Ida M. Whitson	James L. McCurdy	130 E. Fort Ave

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JAN 3 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11409

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 239 Hanover street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 239 Hanover street

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) (Last) Jennings

4. DATE OF DEATH: (Month) 12 / (Day) 9 / (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: About 1869

9. AGE last birthday: 80 yrs. — If under 1 year: Months 8 Days 15 — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dressmaking Teacher

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Moses Henry Jennings

14. MOTHER'S MAIDEN NAME: Harriet C. Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT: Daniel Thomas Jennings

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331 **Immediate cause** (a) Cerebral Hemorrhage — 5 days

83a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arterial Hypertension — ?

(c) Arterio - sclerosis — ?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 4, 1949, to Dec. 9, 1949, that I last saw the deceased alive on Dec. 8, 1949, and that death occurred at 5-30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John M. Caffey M. D. — ADDRESS 98 Gloucester St. Annapolis Md — DATE SIGNED 12/12/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF 12/13/1949 — NAME OF CEMETERY OR CREMATORY St. Marys — LOCATION (City, town, or county) (State) Annapolis Maryland

DATE REC'D BY LOCAL REG. Dec 12, 1949 — REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR — ADDRESS Mrs. Charles E. Hicks & Son 43-45 Northwest St.

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DEC 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11410

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

1

VS. 41b

1. PLACE OF DEATH: COUNTY: Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville; LENGTH OF STAY (In this place): 9 yr. 15 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Pr.Geo.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lakeland
STREET ADDRESS (If rural, give location): none ✓

3. NAME OF DECEASED (Type or Print): (First) John (Middle) H. (Last) Jones

4. DATE OF DEATH: (Month) 12/28/49 (Day) (Year) 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): separated

8. DATE OF BIRTH: 1/26/03

9. AGE last birthday: 46 yrs. If under 1 year: Months. If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Jones

14. MOTHER'S MAIDEN NAME: Anna Lancaster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service): O

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Lung Tuberculosis	known since 12/28/49
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Schizophrenia, Paranoid Type	known 12/13/49

002

131

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: none (CITY OR TOWN): none (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 12/13/40, 19..., to 12/28/49, 19..., that I last saw the deceased alive on 12/28/49, 19..., and that death occurred at 7:02 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): [signature] M.D. ADDRESS: Crownsville, Md. DATE SIGNED: 12/28/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE: Jan 3, 1950 NAME OF CEMETERY OR CREMATORY: Lakeland M.P. LOCATION (City, town, or county) (State): College Park Md

DATE REC'D BY LOCAL REG.: 12-31-49 REGISTRAR'S SIGNATURE: E.T. Joyce Local Regist.

24. FUNERAL DIRECTOR: Robert L. Snowden ADDRESS: Rockville Md

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MARYLAND STATE DEPARTMENT OF HEALTH

11411

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater R.F.D.; MARYLAND; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. General Hospt.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Emma	G.	King	12	9	1949

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	W.		7-27-1910	39 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housewife	—	Anderson Ind.	U. S. A.

13. FATHER'S NAME John Gray

14. MOTHER'S MAIDEN NAME Minnie Farney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Harry R. King R.F.D. Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Accident	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Papilledema	2 weeks
237 57d	(c) Tumor of brain (not classified)	4 weeks or more

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 12, 1949, to Dec. 8, 1949, that I last saw the deceased alive on Dec 8, 1949, and that death occurred at 11 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John N. Caffey M.D.		98 Gloucester St. Annapolis Md.	12-13-49

23. BURIAL, ~~CREMATION~~, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	12-14-49	Arlington Memorial	Arlington	Va

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
12/13/49	[signature]	John W. Sayles Son	Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

11413

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH · COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fort George G Meade | LENGTH OF STAY (in this place): 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Station Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie
STREET ADDRESS (If rural give location): 214 Kent Road

3. NAME OF DECEASED (Type or Print): (First) Norman (Middle) Leo (Last) Lucy

4. DATE OF DEATH: (Month) December (Day) 15 (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 3 July 1898

9. AGE last birthday: 51 yrs. | If under 1 year: Months 5 Days 12 | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Army Officer

10b. KIND OF BUSINESS OR INDUSTRY: US Army

11. BIRTHPLACE (State or foreign country): New London, Conn.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: William Lucy

14. MOTHER'S MAIDEN NAME: Eileen Callahan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service) WW#2

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Angeline Lucy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — 2 hrs

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 131a (b) uremia — 72 hrs

(c) hypertensive - cardio-renal disease — 3 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 19 49, to 15 Dec, 19 49, that I last saw the deceased alive on 15 Dec, 19 49, and that death occurred at 12:40 A m., from the causes and on the date stated above.

SIGNATURE: Herbert J Jacobs (Degree or title) Capt MC — ADDRESS: Station Hosp Ft Meade — DATE SIGNED: Dec 17, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 17 Dec 49 — NAME OF CEMETERY OR CREMATORY: Post Cemetery — LOCATION (City, town, or county) (State): Ft Geo G Meade Md

DATE REC'D BY LOCAL REG.: 15 Dec 49 — REGISTRAR'S SIGNATURE: James E Hayes — JAMES E. HAYES Capt MSC

24. FUNERAL DIRECTOR — ADDRESS: Lilly & Zeiler Inc, Baltimore Md

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BUREAU V. S.

11412

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 1 yr. 7 mos 5 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 1417 W. Saratoga Street

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Elizabeth Lee			4. DATE OF DEATH (Month) (Day) (Year): 12/19/49 19	
5. SEX: female	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: ~~now known~~ about 1874	9. AGE last birthday: 75(?) yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not known	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): not known	12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME: Ben Lee		14. MOTHER'S MAIDEN NAME: not known		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)	16. SOCIAL SECURITY No.: none	17. INFORMANT: Hospital Records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	known since 12/16/49
Antecedent cause(s)	(b)	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Senile Psychosis	known since 5/14/48

331

83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none	19b. MAJOR FINDINGS OF OPERATION: none	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify): none	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none	(CITY OR TOWN) (COUNTY) (STATE): none
TIME OF INJURY (Month) (Day) (Year) (Hour): none m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 5/14/48, 19....., to 12/19/49, 19....., that I last saw the deceased alive on 12/19/49, 19....., and that death occurred at 8:15 A.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Neale Mangenstein	M.D.	Crownsville, Md.	12/19/49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify)	DATE: 12/27/49	NAME OF CEMETERY OR ~~CREMATORY~~: Hospital	LOCATION (City, town, or county) (State): Crownsville Md.
DATE REC'D BY LOCAL REG.: 12/27/49	REGISTRAR'S SIGNATURE: E. F. Joyce. Local Reg.	24. FUNERAL DIRECTOR: Supt. Hospital	ADDRESS: Crownsville Md

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU U. S.

11414

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN South River
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Aberdeen

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R.F.D. Annapolis
STREET ADDRESS (If rural give location) South River

3. NAME OF DECEASED (Type or Print) (First) Augusta (Middle) Burwell (Last) Melvin
4. DATE OF DEATH (Month) 12 (Day) 9 (Year) 1949
5. SEX F
6. COLOR OR RACE W
7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH 12-21-1884
9. AGE last birthday 64 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10h. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) A. A. Co Md.
12. CITIZEN OF WHAT COUNTRY U.S.N.
13. FATHER'S NAME Elliott H. Burwell
14. MOTHER'S MAIDEN NAME Augusta Sollers
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Ridgely P. Melvin Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH 1 yr.

201
44b

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19h. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug., 1949, to 11-9-, 1949, that I last saw the deceased alive on 11-9-, 1949, and that death occurred at 1 48 p.m., from the causes and on the date stated above.

SIGNATURE James R. Martin (Degree or title) M.D. ADDRESS Annapolis, Maryland DATE SIGNED

23. BURIAL, ~~CREMATION REMOVAL (Specify)~~ Burial
DATE THEREOF 12-11-49
NAME OF CEMETERY OR CREMATORY Cedar Bluff
LOCATION (City, town, or county) Annapolis (State) Md
DATE REC'D BY LOCAL REG. 12/10/49
REGISTRAR'S SIGNATURE [illegible] J. Trunk
24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11415

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): one year 11 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 1805 Lauretta Avenue

3. NAME OF DECEASED (Type or Print): (First) Florence (Middle) (Last) Mills

4. DATE OF DEATH: (Month) 12/2/49 (Day) (Year) 19

5. SEX: female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: 11/7/01

9. AGE last birthday: 48 yrs. If under 1 year Months Days; If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laundry worker

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frank Johnson

14. MOTHER'S MAIDEN NAME: Roxanna Forest

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): ******

16. SOCIAL SECURITY NO.: ******

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Carcinoma of Cervix	known since 9/20/48
171 Antecedent cause(s)		
48a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Schizophrenia, Paranoid Type	known since 1/2/47

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ******

19b. MAJOR FINDINGS OF OPERATION: ******

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ******
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: ******
(CITY OR TOWN): ******
(COUNTY)
(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): ******
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? ******

22. I hereby certify that I attended the deceased from 1/2/47, 19..., to 12/2/49, 19..., that I last saw the deceased alive on 12/2/49, 19..., and that death occurred at 8:50 A.M., from the causes and on the date stated above.

SIGNATURE: Jacob Rappaport (Degree or title) M.D. ADDRESS: Crownsville, Maryland DATE SIGNED: 12/2/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 12/5/49
NAME OF CEMETERY OR CREMATORY: Arbutus Memorial Park
LOCATION (City, town, or county): Arbutus (State): Md

DATE REC'D BY LOCAL REG.: 12/5/49
REGISTRAR'S SIGNATURE: Dan. Heduck

24. FUNERAL DIRECTOR: Joseph L. Russo ADDRESS: 1200 McCulloh St

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11416

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville
STREET ADDRESS (If rural, give location) Benfield Road

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Annie	Katharine	Morgan	Dec	6	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Female	White	Widow	Nov. 7. 1865	84 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry A Claus
14. MOTHER'S MAIDEN NAME: Ernestine R Lambrecht

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Caroline C Moore, Benfield Rd

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 **Immediate cause** (a) Uremia - Chronic Nephritis — 1 week

1316 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteria sclerotic Heart Disease — 4 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Oct, 1946, to Dec 6, 1949, that I last saw the deceased alive on Dec 5, 1949, and that death occurred at 8:30 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Edward G Merritt	M.D.	Crumpville Md	Dec 6 1949.

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	12/8/49.	London Park	Baltimore Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
12/7/49	Aw Bedwell Dr.	J M Cook Son	1217 Lond St

11417

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Balti.City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 12 yrs. 21/2 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 1029 Bennett Place

3. NAME OF DECEASED (Type or Print)	(First) Estelle	(Middle)	(Last) Murdock	4. DATE OF DEATH	(Month) 12/13/49 (Day) (Year) 19
5. SEX: female	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed	8. DATE OF BIRTH: ~~not known~~ about 1874	9. AGE last birthday: 75(?) yrs.	If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not known	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME: James Moore	14. MOTHER'S MAIDEN NAME: Not known				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Hospital Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
450.0 Immediate cause	(a) Generalized Arteriosclerosis	known since two years
Antecedent cause(s)		
97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Schizophrenia, Paranoid Type	known since 9/20/37

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/20/37, 19....., to 12/13/49, 19....., that I last saw the deceased alive on 12/13/49, 19....., and that death occurred at 4:40 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern	M.D.	Crownsville, Md.	12/13/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Dec. 16, 1949	NAME OF CEMETERY OR CREMATORY: Mt. Auburn	LOCATION (City, town, or county) (State): Baltimore, Md.
DATE REC'D BY LOCAL REG.: 12-24-49	REGISTRAR'S SIGNATURE: A. W. Hedrick JS	24. FUNERAL DIRECTOR: Holland Funeral Home	ADDRESS: 1631 Druid Hill Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11418

Reg. Dist. No. 21

1. PLACE OF DEATH · COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton, Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Baby (Middle) Boy (Last) Neitzey			4. DATE OF DEATH (Month) Dec (Day) 9 (Year) 1949		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Dec. 8, 1949.	9. AGE last birthday 1 day yrs.	If under 1 year Months. Days; If under 24 hrs. Hours 1 day Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Annapolis Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter N. Neitzey			14. MOTHER'S MAIDEN NAME Amy R McNalley		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) no	16. SOCIAL SECURITY NO. none		17. INFORMANT AND ADDRESS Walter N. Neitzey, Churchton, Md.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Adelectasis, Cerebral hemorrhage

762.0 Antecedent cause(s)

1600 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION no	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) no	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 8, 1949, to Dec 9, 1949, that I last saw the deceased alive on Dec 9, 1949, and that death occurred at 8:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Emily H. Wilson, M D	Lothian, Md.	12-11-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Dec 12 1949	NAME OF CEMETERY OR CREMATORY Washington Memorial Park	LOCATION (City, town, or county) (State) Colesville Md
DATE REC'D BY LOCAL REG. 12/11/49	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR T A Hardesty & Son, Colesville Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 15 1949
BUREAU V. S.

11419

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. Co. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md
STREET ADDRESS (If rural give location) 44 Madison St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) AMANDA DAMMEYER NEUMANN

4. DATE OF DEATH (Month) (Day) (Year) 12 1 1949

5. SEX Female
6. COLOR OR RACE White
7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~ (Specify)
8. DATE OF BIRTH 10-29-1879
9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Annapolis Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Christian Dammeyer
14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY No.
17. INFORMANT Mr. Christian Neumann Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Liver with
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Metastasis to surrounding
(c) structures

155
46 f

INTERVAL BETWEEN ONSET AND DEATH: 6 months

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis — Several years

19a. DATE OF OPERATION Oct 6 - 49
19b. MAJOR FINDINGS OF OPERATION Carcinoma of Liver & Surrounding tissue.
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1949, to Dec 1, 1949, that I last saw the deceased alive on Dec 1, 1949, and that death occurred at 10 30 p.m., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M. D. ADDRESS Annapolis Md DATE SIGNED 12-2-49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF 12-6-49 NAME OF CEMETERY OR CREMATORY Arlington National LOCATION (City, town, or county) (State) Arlington Va.

DATE REC'D BY LOCAL REG. Dec 5, 1949 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 6 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11420

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Jct. — LENGTH OF STAY (In this place) 2 hrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jessups
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location) R.F.D. ✓

3. NAME OF DECEASED (Type or Print)	(First) Stuart	(Middle) Earl	(Last) Oberlin	4. DATE OF DEATH	(Month) Dec. (Day) 1 (Year) 1949
5. SEX M.	6. COLOR OR RACE White	7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify) married	8. DATE OF BIRTH Oct. 12, 1878	9. AGE last birthday 71 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Clarion County, Penn.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Oberlin	14. MOTHER'S MAIDEN NAME Mary Jane Randall				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 214-12-7332	17. INFORMANT Mrs Elisabeth Marshall			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	Sudden
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
940	(c)	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Gustave H. Faulkner MS.	assistant deputy med. examiner	Glen Burnie Md.	12/1/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Dec. 3 1949	NAME OF CEMETERY OR CREMATORY Meadow Ridge Mem Park	LOCATION (City, town, or county) Darsey Maryland (State)
DATE REC'D BY LOCAL REG. Dec 3. 49	REGISTRAR'S SIGNATURE Clara Haslup	24. FUNERAL DIRECTOR De Witt Donaldson Laurel	ADDRESS Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
DEC 29 1949
BUREAU V. S.

11421

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH · COUNTY: Anne Arundel · MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Pennsylvania · COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Severna Park · LENGTH OF STAY (in this place): 4 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Cedar Crest Nursing Home	STREET ADDRESS (If rural, give location): 3236 E. Lanvale St.

3. NAME OF DECEASED (Type or Print) (First) John (Middle) 1 (Last) Padgett			4. DATE OF DEATH (Month) 12 (Day) 4 (Year) 1949		
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: Aug-6-1864	9. AGE last birthday: 85 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer	10b. KIND OF BUSINESS OR INDUSTRY: Own Farm	11. BIRTHPLACE (State or foreign country): Virginia	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: ? Padgett		14. MOTHER'S MAIDEN NAME: unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT AND ADDRESS: Mrs. Munroe - 2417 W. North Ave			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) General Arteriosclerosis	Unknown
450.0 Antecedent cause(s)		
97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Senility	Unknown
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/30, 1949, to 12/3, 1949, that I last saw the deceased alive on 12/3, 1949, and that death occurred at 3:45 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Gustave H. Pauker	M.D.	Glen Burnie	12/4/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Dec-6-49	Parkwood Cem.	Parkville - Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
12/5/49	H. W. Hedrick	F. B. Wippert & Son - 1300	Eutaw Pl 17

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

From here back —

Copied AMS

11422

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 242

1. PLACE OF DEATH — COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Edgewater
LENGTH OF STAY (In this place): 7 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Woodland Beach

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Edgewater
STREET ADDRESS (If rural, give location): Woodland Road

3. NAME OF DECEASED (Type or Print): (First) BASILO (Middle) (Last) PAVLOPOULOS
4. DATE OF DEATH: (Month) Dec. (Day) 21 (Year) 1949
5. SEX: female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 1880
9. AGE (Last birthday): 69 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Greece
12. CITIZEN OF WHAT COUNTRY? Greece
13. FATHER'S NAME: XRONI XROPOULOS
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: NICK PAVLOS.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

4221 Immediate cause (a) Cerebral Hemorrhage — Sudden

938 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio-sclerotic vascular disease — unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

John M. Caffey, M.D. Deputy Medical Examiner Annapolis Md. 12/24/49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

12/24/49 | CEDAR HILL | SUITLAND MD.

DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS

Dec. 22-49 | Carrie Campbell. | J. Wm Lee's Sons Co. | 300-4th St N.E. Wash, D.C.

Mr. Edward Allinson J.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

RECEIVED
DEC 24 1949
BUREAU V. S.

11423

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Caroline (Middle) Ada (Last) Payne

4. DATE OF DEATH (Month) 12 (Day) 20 (Year) 1949

5. SEX F

6. COLOR OR RACE W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH Nov 13th 1871

9. AGE last birthday 78 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Baltimore M.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME William H. Cullimore

14. MOTHER'S MAIDEN NAME Emily Ward

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT Irma Payne Schiaffino

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
170	Immediate cause	(a) Carcinoma of the Lung	15 month.
50	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of the Breast	2 years.
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION Jan. 1947

19b. MAJOR FINDINGS OF OPERATION Carcinoma of the Breast

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) (STATE) —

TIME OF INJURY (Month) (Day) (Year) (Hour) — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Jan., 1947, to Dec. 20, 1949, that I last saw the deceased alive on Dec 20, 1949, and that death occurred at 7 45 P m., from the causes and on the date stated above.

SIGNATURE James S. Billingsley (Degree or title) ADDRESS 108 Central Ave. Glen Burnie Md DATE SIGNED Dec. 21, 1949.

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF Dec 23. 1949. NAME OF CEMETERY OR CREMATORY Woodlawn Cem. LOCATION (City, town, or county) Baltimore (State) Md.

DATE REC'D BY LOCAL REG. 12/22/49 REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR John M. Taylor-Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 24 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11424

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie Md. | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
STREET ADDRESS (If rural give location) Box 274 Crain Highway

3. NAME OF DECEASED (Type or Print): (First) Jack (Middle) Peltz (Last)
4. DATE OF DEATH: (Month) Dec. (Day) 13 (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Married	July 1882	67 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Poland	

13. FATHER'S NAME Blazij Peltz
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
No		Mary Peltz Crain Highway

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Cancerous Lung	6 months
Antecedent cause(s) (b) Cardio Vascular Disease	2 yrs.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —	

163 47d

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—		—		

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from May 15 19 49 to Dec 13 49, that I last saw the deceased alive on Dec 10, 19 49 and that death occurred at 3 35 p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jack Lipke M.D.		Odenton Md	

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Dec 17/49	St Stanislaus	Baltimore

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
12/15/49	A. W. Hesick	Fred W Ozazewski	1936 Eastern Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

11425

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: A.A. Co General

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eastport
STREET ADDRESS (If rural give location): 1129 Monroe St.

3. NAME OF DECEASED (Type or Print): (First) Ava (Middle) Maria (Last) Phipps

4. DATE OF DEATH: (Month) Dec. (Day) 15 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify): Single

8. DATE OF BIRTH: 3-21-1949

9. AGE last birthday: ____ yrs. If under 1 year Months: 8 Days: 24 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: George Phipps

14. MOTHER'S MAIDEN NAME: Julia Frey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: George Phipps

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
571.0	Immediate cause	(a) Cirhal Thrombosis	2 days
1190	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Epidmic Vomiting and Diarrhea	7 days
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Coodition contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Mooth) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12 Dec, 1949, to 15 Dec, 1949, that I last saw the deceased alive on 15 Dec, 1949, and that death occurred at 6 35 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Phil Preece M.D. ADDRESS: 212 Prince George St Annapolis Md DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): DATE THEREOF 12-18-49 NAME OF CEMETERY OR CREMATORY: St Mary's LOCATION (City, town, or county) (State): Annapolis Md

DATE REC'D BY LOCAL REG. Dec. 17, 1949 REGISTRAR'S SIGNATURE: W. J. Lynch

24. FUNERAL DIRECTOR ADDRESS: John M. Taylor Sr Annapolis Md.

RECEIVED
DEC 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11426

CERTIFICATE OF DEATH

Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel; LENGTH OF STAY (In this place) 22 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS District Training School

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN District Training School; STREET ADDRESS (If rural, give location) Near Laurel

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William	McKinley	Pierpont	Dec.	8	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	W	widowed	May 4 1896	53 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer Sheepman	District Training School	Howard Co. Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Charles Pierpont	Georgianna T. Cross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no		Mrs. Elmer Pierpont

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Haemorrhage	3 days.
331 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 83a	(b) Arteria-sclerosis	1 yr.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 12/1/49, 19..., to 12/8/49, 19..., that I last saw the deceased alive on 12/8/49, 19..., and that death occurred at ...m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank Shipley	M.D.	Savage, Md.	12/9/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Buried	12/12/49	St. Paul's Lutheran Cem.	Fulton, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
12-12-49	Clara Hastup	Dewitt Donaldson	Laurel Md.

VS. A15

RECEIVED
DEC 29 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11427

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bristol
LENGTH OF STAY (in this place) 80 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bristol
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Anne (Middle) (Last) Pindell

4. DATE OF DEATH (Month) Dec (Day) 26 (Year) 49

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH 3-7-69

9. AGE last birthday 80 yrs. If under 1 year Months. Days. If under 24 hrs. Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Bristol, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Robert M. Pindell

14. MOTHER'S MAIDEN NAME Mary Francis Drury

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT AND ADDRESS Mrs. Beall Sasscer, Upper Marlboro, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Generalized Arteriosclerosis	20 yrs
450.0 Antecedent cause(s)		
97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chr. Malnutrition & Cachexia	5 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1949, to Dec, 1949, that I last saw the deceased alive on 26 Dec, 1949, and that death occurred at 8:35 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Robert B Sasscer MD Upper Marlboro, Md Dec 24, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE 12,27, 49

NAME OF CEMETERY OR CREMATORY Pindell

LOCATION (City, town, or county) (State) Bristol, Md.

DATE REC'D BY LOCAL REG. Dec 27 1949

REGISTRAR'S SIGNATURE W.P. Clayton Registrar

24. FUNERAL DIRECTOR T.A. Hardesty & Son ADDRESS Galesville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 30 1949
BUREAU U. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11428

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH
COUNTY A. A. Co. STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hanover
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dorsey Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hanover
STREET ADDRESS (If rural, give location) Dorsey Rd.

3. NAME OF DECEASED (Type or Print): (First) RUTH (Middle) ANN (Last) RAY

4. DATE OF DEATH: (Month) Dec. (Day) 19 (Year) 19 49

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: June 26, 1949

9. AGE last birthday: -5- yrs. If under 1 year: Months 5 | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Balto., Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: R. Walden Ray

14. MOTHER'S MAIDEN NAME: Norma S. Shipley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. -

17. INFORMANT: Mr. R. Walden Ray, Dorsey Rd. Hanover, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Bronchitis	1 day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (470 / 106a)	(b) Common Cold	2 days
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 19th, 1949, to Dec. 19th, 1949, that I last saw the deceased alive on Dec. 19, 1949 and that death occurred at 4:45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Frank Shipley M. D. Savage, Md. 12/20/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 12/21/49 | NAME OF CEMETERY OR CREMATORY: Meadow Ridge Mem. | LOCATION (City, town, or county) (State): Howard Co., Md.

DATE REC'D BY LOCAL REG. 12/21/49 | REGISTRAR'S SIGNATURE Mrs Hedrick | 24. FUNERAL DIRECTOR: WM. J. TICKNER & SONS | ADDRESS: Balto., Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

11429

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 5 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 1205 LAURENS St. ✓

3. NAME OF DECEASED (Type or Print): (First) Lillian (Middle) (Last) Redman

4. DATE OF DEATH: (Month) Dec (Day) 9 (Year) 19 49

5. SEX: female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: June 13, 1868

9. AGE last birthday: 81 yrs. — If under 1 year: Months: 5 Days: 26 — If under 24 hrs.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Days Work

11. BIRTHPLACE (State or foreign country): Balto, Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Enoch W. Trusty

14. MOTHER'S MAIDEN NAME: Rebecca A. Trusty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Gertrude Wiley - 100 W. 138th St. New York, N.Y.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443 Immediate cause (a) Cerebral Hemorrhage — 2 Days

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension - Cardio vascular disease — since Oct 23, 1944

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senile Psychosis — since Oct 23, 1944

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 23, 19 44, to Dec 9, 19 49, that I last saw the deceased alive on Dec 9, 19 49 and that death occurred at 8:15 P m., from the causes and on the date stated above.

SIGNATURE: Acob Mengusten (Degree or title) M.D. ADDRESS: DATE SIGNED:

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 12/13/49 — NAME OF CEMETERY OR CREMATORY: Mt Auburn Cemetery — LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REG.: 12/12/49 — REGISTRAR'S SIGNATURE: A. W. Fedrick

24. FUNERAL DIRECTOR: Charles R. Law — ADDRESS: 802 Madison Ave Balto 1, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11430

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: A.A. Co. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gambrills
LENGTH OF STAY (in this place): 6 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Ft. Meade Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gambrills
STREET ADDRESS (If rural, give location): Ft. Meade Rd.

3. NAME OF DECEASED (Type or Print): (First) TINA (Middle) LUCILE (Last) REEDY

4. DATE OF DEATH: (Month) 12 (Day) 4 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Oct 12, 1940

9. AGE last birthday: 9 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Russell M. Reedy

14. MOTHER'S MAIDEN NAME: Annette Schneider

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.:

17. INFORMANT: Mr R. M. Reedy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Upper Respiratory Infection	2 weeks.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Spastic Paralysis	9 Years.
	(c)	

351 81e

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from Oct, 1946, to Dec 4, 1949, that I last saw the deceased alive on ~~Dec~~ Dec. 2, 1949, and that death occurred at 10:15 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Edward J Merritt	M.D.	Gambrills Md	Dec 4, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	12-6-49	St. Stephens	Gambrills, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
12-4-49	E.F. Joyce Local Reg.	B.L. Hopping & Son	Annapolis, Md.

RECEIVED
DEC 7 1949
BUREAU V. M.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

11431

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jewell
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Lester Grayson's Farm

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jewell
STREET ADDRESS (If rural, give location) Hutchins Farm

3. NAME OF DECEASED (Type or Print): (First) JAMES (Middle) EDWARD (Last) RIGGS

4. DATE OF DEATH: (Month) Dec. (Day) 12 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: May 31. 1917

9. AGE last birthday: 32 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Farming.

11. BIRTHPLACE (State or foreign country): A. A. Co

12. CITIZEN OF WHAT COUNTRY: U. S.

13. FATHER'S NAME: Columbus Riggs

14. MOTHER'S MAIDEN NAME: Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Wm C. Riggs

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Homicide	Sudden
981 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Shot thru mouth Bullet in Skull	
166	(c) .22 cal revolver	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Farm

(CITY OR TOWN) Jewell (COUNTY) A. A. (STATE) Md

TIME (Month) (Day) (Year) (Hour) OF INJURY: Dec. 12 1949 1:30 p.m.

INJURY OCCURRED While at work ☐ Not while at work ☑

HOW DID INJURY OCCUR? Shot from .22 cal Revolver.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above; and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Claffy M.D., Deputy Medical Examiner Annapolis Md 12/12/49

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF: DEC. 15 1949 NAME OF CEMETERY ~~OR CREMATORY~~: Union Chapel LOCATION (City, town, or county) (State): Mt. Pendree A. A. Md

DATE REC'D BY LOCAL REG. 12/14/49 REGISTRAR'S SIGNATURE: W. R. Clayton Dep. Reg.

24. FUNERAL DIRECTOR: J. A. Hardesty & Son ADDRESS: Galesville Md.

RECEIVED
DEC 16 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11432

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place) 5 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS.
STREET ADDRESS (If rural give location) R.F.D. Route 3 Box 533.

3. NAME OF DECEASED (Type or Print): (First) WALTER (Middle) (Last) ROBINSON

4. DATE OF DEATH: (Month) Dec. (Day) 31 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 12-23-03

9. AGE last birthday: 46 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Coal Power

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Robinson

14. MOTHER'S MAIDEN NAME: Jane Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Elizabeth Robinson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute heart failure	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Sub-acute endocarditis	2 weeks
	(c)	

430.1
912

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md. DATE SIGNED 12/31/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE THEREOF Jan. 2/50 NAME OF CEMETERY OR CREMATORY Mt. Calvary LOCATION City, town, or county: Brooklyn A.A. Co. (State)

DATE REC'D BY LOCAL REG. Jan 1, 1950 REGISTRAR'S SIGNATURE W. T. Branch

24. FUNERAL DIRECTOR J.B. Henson ADDRESS Annapolis

VS. A15A

RECEIVED
JAN 4 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11433

Reg. Dist. No. .....

1. PLACE OF DEATH:
County A.A. Co.
City or town Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
Creek & Harlem Roads
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A. Co.
City or town Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No. Creek & Harlem Roads
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME Robert Davis Roe

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife Florence M. (Chapman)
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Aug. 27, 1904

8. AGE:

Years	Months	Days	If less than one day
45	3	22	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation Marine Fireman
11. Industry or business Baltimore City
FATHER 12. Name William Roe
13. Birthplace ----
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
16. Informant Mrs. Florence Roe
Address Riviera Beach, A.A.Co.Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 22/49 (month) (day) (year)
Cemetery or crematory Mt. Olivet
Location 2930 Frederick Rd. Balto. Md.
18. Funeral director Harry H. Wintzfe
Address 4101 Edmondson Ave.
19. Dec 22 19 49 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19/49 19 ..... at ..... M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 16 1949 to Dec 20 1949
and that I last saw him alive on Dec 19 1949
Immediate cause of death Angina Pectoris DURATION
Due to .....
Due to .....
Other conditions 420.2 94b (Include pregnancy within 3 months of death)
Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Thos. H. Phillips M. D. or other
Address 3307 Edmondson Date signed Dec 21 49

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
VS A15 9-45-15M

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

T

MARYLAND STATE DEPARTMENT OF HEALTH

11434

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. Co General Hospt.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harwood
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Frank (Middle) Richard (Last) James
4. DATE OF DEATH (Month) 12 (Day) 14 (Year) 1949
5. SEX Male
6. COLOR OR RACE White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH July 3-1881
9. AGE last birthday 68 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farmer
11. BIRTHPLACE (State or foreign country) Farmington Conn
12. CITIZEN OF WHAT COUNTRY N. S. A.
13. FATHER'S NAME —
14. MOTHER'S MAIDEN NAME Effie Bryant
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Lillian L. Gomes Harwood A A Co Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Coronary occlusion	2 mins.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	arteriosclerotic coronary disease	10 years
	(c)	hypertension	" "

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 11, 1949, to Dec. 14, 1949, that I last saw the deceased alive on Dec. 13, 1949, and that death occurred at 8:20 a. m., from the causes and on the date stated above.

SIGNATURE Emily H. Wilson (Degree or title) M.D. ADDRESS Lothian, Md. DATE SIGNED 12-16-49

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF 12-17-49 NAME OF CEMETERY OR CREMATORY All Hallows Church LOCATION (City, town, or county) Mt. Birdsville (State) Md

DATE REC'D BY LOCAL REG. Dec 17, 1949 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

RECEIVED
DEC 22 1949
BUREAU V. S.

11435

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH: COUNTY Annearundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Baltimore city COUNTY annearundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore city — LENGTH OF STAY (in this place) 7 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore Rural
HOSPITAL OR INSTITUTION OR STREET ADDRESS 300 Riverside road.	STREET ADDRESS (If rural give location) 300 Riverside road

3. NAME OF DECEASED (Type or Print) (First) Fredrick (Middle) Vincent (Last) Schofield

4. DATE OF DEATH (Month) Dec (Day) 1 (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) divorced

8. DATE OF BIRTH Apr 9, 1874

9. AGE last birthday 75 yrs. If under 1 year: Months 7, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fish salesman

10b. KIND OF BUSINESS OR INDUSTRY Fish business

11. BIRTHPLACE (State or foreign country) Cecilton Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John C Schofield

14. MOTHER'S MAIDEN NAME Miss Anna McCafferty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. —

17. INFORMANT Mrs Marie Wehberg.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
199.8	Immediate cause	(a) Carcinoma of Larynx, trachea & oesophagus	4 mths
46a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) None	
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchitis, inability to swallow, [illegible], Anemia, loss weight etc

19a. DATE OF OPERATION None

19b. MAJOR FINDINGS OF OPERATION None

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) None

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 4, 1949, to Dec 1, 1949, that I last saw the deceased alive on Dec 1, 1949 and that death occurred at 300 Riverside Road Annearundel m., from the causes and on the date stated above.

SIGNATURE B V Kelly MD (Degree or title) Port Surgeon ADDRESS 100 N Linwood Ave Balto Md DATE SIGNED Dec 2 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Dec 3/49

NAME OF CEMETERY OR CREMATORY West Minister

LOCATION (City, town, or county) Georgetown Md (State)

DATE REC'D BY LOCAL REG. 12-6-49

REGISTRAR'S SIGNATURE Mrs. Ida M. Whitson

24. FUNERAL DIRECTOR B R Fellows ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 6 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11436

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jessup; LENGTH OF STAY (in this place) 4 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jessup; STREET ADDRESS (If rural give location) Camp Mead Rd

3. NAME OF DECEASED (Type or Print): (First) John (Middle) T. A. (Last) Straup

4. DATE OF DEATH: (Month) Dec (Day) 8 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: April 26 1864

9. AGE last birthday: 85 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Engineer

10b. KIND OF BUSINESS OR INDUSTRY: B&O R.R

11. BIRTHPLACE (State or foreign country): Shepherdstown W Va

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: Edward Straup

14. MOTHER'S MAIDEN NAME: Mary Lowman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 213-12-2644

17. INFORMANT: Mrs Alethea E Foreacre

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis.	15 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chr. Myocarditis	1 yr.
420.1 93d	(c) Hypertension.	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify): —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 24, 1949, to Dec. 8th, 1949, that I last saw the deceased alive on 12/8/49, 19....., and that death occurred at 8:30 a. m., from the causes and on the date stated above.

SIGNATURE Frank Shipley (Degree or title) M. D. ADDRESS Savage, Md. DATE SIGNED 12/8/49.

23. BURIAL, CREMATION REMOVAL (Specify): Bur | DATE THEREOF Dec 10/1949 | NAME OF CEMETERY OR CREMATORY Lorraine | LOCATION (City, town, or county) Balto (State) Md.

DATE REC'D BY LOCAL REG. 12/9/49 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR C. Howard Evans | ADDRESS 1440 N Charles

11437

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hosptial	STREET ADDRESS (If rural give location) 1000 West St.

3. NAME OF DECEASED (Type or Print) (First) William (Middle) Edward (Last) Suit				4. DATE OF DEATH (Month) 12-31-49 (Day) (Year) 19		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May 19, 1873	9. AGE last birthday 76 yrs.	If under 1 year Months 6 Days 12	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) night watchman		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Davidsonville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Wesley Suit			14. MOTHER'S MAIDEN NAME Mary Ellen Walker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-28-0154	17. INFORMANT Mrs. Bertha Suit 1000 West St. Annap.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) arteriosclerotic cardiovascular disease	15 yrs
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
93d	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1942, to 12/31, 1949, that I last saw the deceased alive on 12/31, 1949, and that death occurred at 8:00 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
S. Borosach	MD	Annapolis Md	12/3/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 1-2-50	NAME OF CEMETERY OR CREMATORY Davidsonville Methodist	LOCATION (City, town, or county) (State) Davidsonville, Maryland
DATE REC'D BY LOCAL REG. Jan. 2, 1950	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR B.L. Hopping and Son	ADDRESS Annapolis, Md.

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 4 1950
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11438

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport; HOSPITAL OR INSTITUTION OR STREET ADDRESS —; MARYLAND; LENGTH OF STAY (in this place)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY aa; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport; STREET ADDRESS (If rural give location) 514 Burnside Ave

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) R. (Last) Thomas

4. DATE OF DEATH: (Month) 12 (Day) 31 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify)

8. DATE OF BIRTH: Oct-13th-1902

9. AGE last birthday: 47 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Randolph Bowman

14. MOTHER'S MAIDEN NAME: Ann Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT: Earnest Thomas Eastport Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Potts disease - Lumbar Spine

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c) —

INTERVAL BETWEEN ONSET AND DEATH

012.0
16

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1949, to 12-31, 1949, that I last saw the deceased alive on 12-31, 1949, and that death occurred at 9 A.M., from the causes and on the date stated above.

SIGNATURE Elmhurst (Degree or title) M.D. ADDRESS Eastport Md DATE SIGNED 1-2-50

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 1-3-1950 | NAME OF CEMETERY OR CREMATORY Cedar Bluff | LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Jan. 3, 1950 | REGISTRAR'S SIGNATURE H. T. Branch

24. FUNERAL DIRECTOR John W. Taylor, Son ADDRESS Annapolis Md.

RECEIVED
JAN 4 1950
BUREAU U. S.

11439

...ive Service System
...cal Board No. 31
JAN 5 1950
...92 Gloucester Street
Annapolis, Anne Arundel Md.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 191 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville State Hosp. LENGTH OF STAY (In this place) 21 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Maritsville Howard County
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Maritsville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) THEODORE (Middle) (Last) THOMAS #1.
4. DATE OF DEATH (Month) DEC (Day) 30 (Year) 1949
5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH 1907
9. AGE last birthday 42 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland, Howard County
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Charles Thomas
14. MOTHER'S MAIDEN NAME Brenda Griffith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Hosp. records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Freezing
932.9 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Exposure — 3 days
190 (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner. ADDRESS Annapolis Md DATE SIGNED 12/31/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF 1-3-1950 NAME OF CEMETERY OR CREMATORY West Liberty LOCATION (City, town, or county) Alpha Md (State)

DATE REC'D BY LOCAL REG. Jan 2, 1950 REGISTRAR'S SIGNATURE John B. Loughran Per. Mr. E. Fletcher Joyce B.E.L.
24. FUNERAL DIRECTOR F. C. Higinbothom ADDRESS Elliott City Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JAN 11 1960
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11440

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Found: public dump at Hammonds Lane near Old Annapolis Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Unknown; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Unknown; STREET ADDRESS (If rural, give location) Unknown

3. NAME OF DECEASED (Type or Print): (First) Unidentified; (Middle); (Last)

4. DATE OF DEATH: (Month) (Day) (Year) December 17, 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH

9. AGE last birthday: yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min. newborn 3

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Exposure

983 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 165 (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY public dump

(CITY OR TOWN) Hammonds Lane near Old Annapolice Rd. (COUNTY) A.A. Co.Md. (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY December 17, 1949 m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Exposure

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE R. B. Fisher (Degree or title) M.D. ADDRESS 700 Fleet Street, Baltimore 2, Md. DATE SIGNED 12-21-49

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL

LOCATION (City, town, or county) (State) DEC 21 1949

DATE REC'D BY LOCAL REG. 1-2-49

REGISTRAR'S SIGNATURE R. W. Hedrick

24. FUNERAL DIRECTOR

ADDRESS

RECEIVED
JAN 2 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11441

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Revere Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Lake & Creek Roads

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Revere Beach

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Lake & Creek Roads

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Millington Von Holten

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Blanche Hubbard

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 10, 1887

8. AGE: Years: 62 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Insurance

FATHER 12. Name: William Von Holten

FATHER 13. Birthplace: —

MOTHER 14. Maiden name: Ella J Leming

MOTHER 15. Birthplace: —

16. Informant: Blanche Von Holten

Address: Revere Beach

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 19, 1949 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Baltimore

18. Funeral director: George A Farley

Address: Funeral Parlor Fayette St. Balto.

19. 12/19 1949 (Date received by registrar) L. J. DeAlba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 15, 1949 at 4 05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1949 to July 23 1949 and that I last saw him alive on July 23 1949

Immediate cause of death	DURATION
Coronary Thrombosis with acute Myocardial Failure	Instant.
Due to Coronary sclerosis	Unknown
Due to Generalized arteriosclerosis	Unknown
Other conditions Chronic degenerative myocarditis with cardiac hypertrophy	

(Include pregnancy within 3 months of death)

420 93d Major findings of operations: None Date of op.: —

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of: —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: A. H. Gordon M.D. M. D. or other

Address: Green Gables, Pasadena, Md. Date signed: 12/20/49

RECEIVED
DEC 21 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11442

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn P.O
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Delmont Sta.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn.
STREET ADDRESS (If rural, give location) Delmont Sta

3. NAME OF DECEASED (Type or Print) (First) PRESTON (Middle) LEE (Last) WARD.
4. DATE OF DEATH (Month) Dec. (Day) 9 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH OCT. 17, 1891
9. AGE last birthday 58 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Alcohol Content Inspector
10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.
11. BIRTHPLACE (State or foreign country) Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George L. Ward.
14. MOTHER'S MAIDEN NAME Nellie Pumphrey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) World War I
16. SOCIAL SECURITY NO. NONE.
17. INFORMANT Inez Ward

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Coronary occlusion	sudden
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Coronary sclerosis	unknown
94a	(c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md. DATE SIGNED 12/10/49

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF DEC. 12, 1949
NAME OF CEMETERY OR CREMATORY FORREST LAWN.
LOCATION (City, town, or county) RICHMOND (State) VA.

DATE REC'D BY LOCAL REG. 12/12/49
REGISTRAR'S SIGNATURE L. J. DeAlba
24. FUNERAL DIRECTOR Thomas W. Singleton, ADDRESS Glen Burnie, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
DEC 14 1949
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11443

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balto City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore, Maryland
STREET ADDRESS (If rural, give location) 567 Baker Street ✓

3. NAME OF DECEASED (Type or Print) (First) Richard (Middle) ----- (Last) Watford
4. DATE OF DEATH (Month) (Day) (Year) 12 - 11 1949

5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH 6/30/38
9. AGE last birthday 11 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----------
10b. KIND OF BUSINESS OR INDUSTRY ----------
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Joseph Watford
14. MOTHER'S MAIDEN NAME Ruth Speller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---------- (If year, give war or dates of service) ----------
16. SOCIAL SECURITY NO. ----------
17. INFORMANT Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

490 Immediate cause (a) Lobar Pneumonia (right lower lobe) known since 12/5/1949

107 Antecedent cause(s) (b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Congenital Idiocy known since 10/6/1947

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION ----------
19b. MAJOR FINDINGS OF OPERATION ----------
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) ********
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ********
(CITY OR TOWN) (COUNTY) (STATE) **********
TIME OF INJURY (Month) (Day) (Year) (Hour) ********** m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? **********

22. I hereby certify that I attended the deceased from 10/6, 1947, to 12/11, 1949, that I last saw the deceased alive on 12/11, 1949, and that death occurred at 6:50 A.m., from the causes and on the date stated above.

SIGNATURE Jacob Morgenstern M. D. (Degree or title) ADDRESS Crownsville, Md. DATE SIGNED 12/11/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 12/15/49
NAME OF CEMETERY OR CREMATORY Mt Auburn
LOCATION (City, town, or county) (State) Md

DATE REC'D BY LOCAL REG. 12/12/49
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR Geo. G. Kelson
ADDRESS 1303 Pressman St

MARYLAND STATE DEPARTMENT OF HEALTH

11444

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly. Give correct age if especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (In this place) 2 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL - Annapolis
STREET ADDRESS (If rural give location) Quarters S-7, North Severn

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Thomas	(none)	WHITE	12	7	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE Last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Single	12-6-49	---- yrs.	----	18 / 31

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
----------	----------	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Donald Foster White	Frances Virginia Edmonds

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	----------	Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) CARDIAC FAILURE	Spontaneous
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) PREMATURITY	18 hours
	(c)	

776
157

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
----------	----------	Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
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TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
---------- m.	----------	----------

22. I hereby certify that I attended the deceased from 12-6- , 1949, to 12-7- , 1949, that I last saw the deceased alive on 12-7- , 1949, and that death occurred at 5:10 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Ralph K. Brooks LT., MC, USN	U.S. Naval Hospital, Annapolis, Md.	12-8-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	12-9-49	Mount Academy	Annapolis Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
12/9/49	Jessie J. Franch	John M. Taylor-Inc	Annapolis Md.

VS. A15

RECEIVED
DEC 15 1949
BUREAU OF U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

11445

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Junction
LENGTH OF STAY (in this place) 2 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Junction
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Bonnie	Ruth	Willis	Dec	10	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
F	W	married	June 5 1910	39 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Hawkins Co Rogersville, Tenn.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Blevins Alvis
14. MOTHER'S MAIDEN NAME: Evelyn Brewer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT: Erving Willis - husband

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral embolism — 1 hours

332 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — (b)

83b (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/10, 1949, to 12/10, 1949, that I last saw the deceased alive on Dead on arrival, 19..., and that death occurred at 10:00 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) William R. Bunge M.D. — ADDRESS Laurel, Md. — DATE SIGNED 12/12/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	12/14/49	Ivy Hill Cemetery	Laurel, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
12-14-49	Clara Haslup	De Witt Donaldson, Laurel Md.	

RECEIVED
DEC 29 1949
BUREAU V. S.

11446

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 26 Calvert St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md.
STREET ADDRESS (If rural give location) 26 Calvert St.

3. NAME OF DECEASED (Type or Print) (First) Johnnie (Middle) (Last) Wilson

4. DATE OF DEATH (Month) 12 (Day) 19 (Year) 1949

5. SEX Male | 6. COLOR OR RACE Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) unk. | 8. DATE OF BIRTH Sept. 3, 1885 | 9. AGE last birthday 64 yrs. | If under 1 year Months Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy | 11. BIRTHPLACE (State or foreign country) Brenham Texas | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown | 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT Discharge Certificate

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Congestive heart failure

443 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio vascular disease

93d

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-9, 1949, to 12-19, 1949, that I last saw the deceased alive on 12-17, 1949, and that death occurred at 8:00 A m., from the causes and on the date stated above.

SIGNATURE G. T. Allen (Degree or title) M.D. ADDRESS 10 Carroll DATE SIGNED 12-21-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 12-23-49 | NAME OF CEMETERY OR CREMATORY Brewer Hill | LOCATION (City, town, or county) (State) Annapolis, Md.

DATE REC'D BY LOCAL REG. 12/2/49 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR William Reese, II ADDRESS 108 Washington St. Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 24 1949
BUREAU V. S.

11447

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
LENGTH OF STAY (in this place) 9 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7 - Virginia ave. N.W.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Same COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same
STREET ADDRESS (If rural, give location) Same

3. NAME OF DECEASED (Type or Print) (First) Marie (Middle) Louise (Last) Zondler
4. DATE OF DEATH (Month) Dec. (Day) 8 (Year) 1949
5. SEX F.
6. COLOR OR RACE White
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED,~~ (Specify) Widow
8. DATE OF BIRTH Aug. 15-1887
9. AGE last birthday 62 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Germany - Europe.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John H. Wichmann.
14. MOTHER'S MAIDEN NAME Anna M. Schlii Nelburg.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY No. No
17. INFORMANT Mrs. Elsie Berry (daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

159 Immediate cause (a) Cancer of Liver and

46 pm Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (Gastro Intestinal Tract.

(c)

INTERVAL BETWEEN ONSET AND DEATH: 1 year +

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 12/1948
19b. MAJOR FINDINGS OF OPERATION as cause of death - above mentioned
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Gustave H. Faubert MD. (Degree or title) assistant Deputy Medical Examiner ADDRESS Glen Burnie, Md DATE SIGNED 12/8/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 12/12/49
NAME OF CEMETERY OR CREMATORY Glen Haven
LOCATION (City, town, or county) (State) A. A. Co. Md.

DATE REC'D BY LOCAL REG. December 10th 1949
REGISTRAR'S SIGNATURE R.W.
24. FUNERAL DIRECTOR Wm Cook Inc. 1217 St. Paul St. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A